



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 4, 2008

Victoria Alexander
Steele Memorial Medical Center
P.O. Box 700
Salmon, Idaho 83467-0700

RE: Steele Memorial Medical Center, provider #131305

Dear Ms. Alexander:

This is to advise you of the findings of the Complaint survey at Steele Memorial Medical Center which was concluded on May 28, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
 3. Identify the date each deficiency has been, or will be, corrected.
-
4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 17, 2008**, and keep a copy for your records.

Victoria Alexander

June 4, 2008

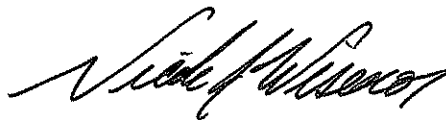
Page 2 of 2

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures



STEELE MEMORIAL MEDICAL CENTER
P.O. BOX 700 ~ SALMON, IDAHO 83467 ~ (208)756-5600 ~ FAX (208) 756-4169

June 16, 2008

RECEIVED

Idaho Department of Health & Welfare
Bureau of Facility Standards

JUN 18 2008

Attn: Gary Guiles and Nicole Wisenor

FACILITY STANDARDS

Please find attached our plan of action regarding Complaint #131305.

Sincerely,

Victoria Alexander-Lane
Chief Executive Officer

**Steele Memorial Hospital
Policy and Procedure**

Page 1 of 1

Title: X-Ray Read and Interpretation		Policy Number: 160-070
Originating Department: Emergency Department	Affected Department: Emergency Department Radiology	
	Effective Date: 06/02/2008	
	Revised Date:	

Purpose:

Ensure that x-rays are read and interpreted in a timely manner in order to provide quality health care in a safe environment.

Procedure:

X-rays ordered in the Emergency Department will be read by the ordering physician and documented in the chart at the time of that visit. Plan of care will be based on that interpretation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/28/2008
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NAME OF PROVIDER OR SUPPLIER

STEELE MEMORIAL MEDICAL CENTER

STREET ADDRESS, CITY STATE, ZIP CODE

**203 SOUTH DAISY STREET
SALMON, ID 83467**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 000

INITIAL COMMENTS

The following deficiency was cited during the complaint survey at your hospital. Surveyors conducting the investigation were:

Gary Guiles, RN, HFS Team Leader
Sharon Mauzy, RN, HFS

C 241

485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL

The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the CAH's governing body failed to implement policies to ensure x-rays would be read in a timely manner in order to provide quality health care in a safe environment. This led to delays in treatment for 1 of 7 patients (#7) who presented to the ED for treatment of traumatic injuries. The findings include:

1. Patient #7 was a 53 year old female who presented to the ER on 12/27/07 at 2:00 PM, following a motor vehicle accident. She had a history of low back pain and had undergone back surgery approximately 3 months earlier. She complained of back and hip pain. She also had pain and spasms when she moved her legs. The physician ordered x-rays of the patient's chest, pelvis, and lumbar spine. These were done. The

C 000

C 241

1. Please note policy # 160-070, x-rays ordered in the ED will be read by the ordering physician and documented in the chart at the time of that visit. Plan of care will be based on that interpretation.

2. Monitor 100% of patient charts receiving x-rays in the ED for 60 days with the expectation of 100% compliance.

06/02/2008

RECEIVED

JUN 18 2008

FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Thomas D. Gagne

CEO

6/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 000	INITIAL COMMENTS	C 000			
C 241	<p>The following deficiency was cited during the complaint survey at your hospital. Surveyors conducting the investigation were:</p> <p>Gary Guiles, RN, HFS, Team Leader Sharon Mauzy, RN, HFS 485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL</p> <p>The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the CAH's governing body failed to implement policies to ensure x-rays would be read in a timely manner in order to provide quality health care in a safe environment. This led to delays in treatment for 1 of 7 patients (#7) who presented to the ED for treatment of traumatic injuries. The findings include:</p> <p>1. Patient #7 was a 53 year old female who presented to the ER on 12/27/07 at 2:00 PM, following a motor vehicle accident. She had a history of low back pain and had undergone back surgery approximately 3 months earlier. She complained of back and hip pain. She also had pain and spasms when she moved her legs. The physician ordered x-rays of the patient's chest, pelvis, and lumbar spine. These were done. The</p>	C 241			

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TITLE

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C 241	Continued From page 1 report by the radiologist, dictated 1/1/08, stated "IMPRESSION: 1. Evidence of lumbar fusion at L4-5, which has been performed since the prior exam from August 9, 2007. 2. New compression fracture at L3 when compared to the exam from August 9, 2007. 3. Mild endplate spurring in the lumbar spine at L2 and L3." Chest and pelvis x-rays were negative for disease. The EMERGENCY ROOM NOTE by the ER physician, dated 12/27/07, stated "BACK: No redness, swelling, or bruising but marked tenderness noted over lower lumbar spine. Some muscle spasm. No other abnormality noted. Range of motion not attempted. Patient reported severe pain with even attempt to lift her leg slightly. Unable to sit up or ambulate to any active testing." The note stated the patient's chest x-ray was negative for disease but did not mention the pelvis or lumbar spine x-rays. The patient was admitted to the hospital for observation. Admitting orders included "May be up as tolerated with assistance". The patient complained of pain in her right hip through out her stay. Nursing notes documented pain in her hip but did not document pain in her back. At 4:20 AM on 12/28/07, the nursing note stated she ambulated with a walker. It said she "DID WELL BUT DOESN'T LIKE TO PUT WT ON (RIGHT) LEG." At 8:02 AM, the nurse documented the patient was sitting up in bed. She was discharged home with her family with a walker at 11:15 AM on 12/28/07. A physician discharge summary, dictated on 1/3/08, stated the patient had right side pain controlled with oral medication. It also stated the patient was ambulating with a walker which was normal for her. Under diagnoses, the physician stated the patient was "admitted for pain control status post MVA with contusion, right hip. She had a syncopal event...however, there is	C 241			

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C 241	<p>Continued From page 2</p> <p>no evidence of acute head trauma." The lumbar fracture was not mentioned. The summary stated the patient was to follow up with her primary care provider. However, no specific discharge instructions were present in the record.</p> <p>2. The physician, who cared for the above patient following discharge from the ER, was interviewed on 5/21/08 at 3:15 PM. He stated he was not aware that lumbar x-rays had been obtained during the patient's hospital stay. He said a radiologist in another town read x-rays for the hospital once per week. He said it appeared the radiologist read the lumbar x-ray on 1/1/08 and probably notified his office of the findings on 1/2/08. He could not absolutely say his office had received the x-ray report because he thought it would have been sent to a physician assistant in his office. The ER physician was not available for interview. The patient, who was interviewed on 5/27/08 at 1:40 PM, stated she had not been informed of the lumbar x-ray findings while she was at the hospital. She said she did not learn of the fracture until a CT scan was performed on 1/23/08.</p> <p>3. The Manager of Radiology and the Director of Radiology were interviewed together on 5/21/08 at 3:50 PM. They said currently the radiologist came to the hospital every Wednesday to read x-rays that had been taken the previous week. Reports were then generated and sent to the providers. They said the hospital had no policy to ensure ER physicians read x-rays or to ensure patients were informed of the findings in a timely manner. It was noted the hospital had recently installed hardware to allow the radiologist to read x-rays remotely which would promote faster turn around times for readings. This system was</p>	C 241			

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C 241	Continued From page 3 expected to be on line in the second half of June, 2008. Even with the new system, the Manager stated this would not guarantee a physician would read x-rays in a timely manner.	C 241			



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT
HEALTH & WELFARE

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

COPY

June 6, 2008

Victoria Alexander
Steele Memorial Medical Center
P.O. Box 700
Salmon, Idaho 83467

Provider #131305

Dear Ms. Alexander:

On **May 28, 2008**, a Complaint Survey was conducted at Steele Memorial Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003577

Allegation: The hospital failed to ensure x-rays were read by a physician in a timely manner.

Findings: An unannounced visit was made to the hospital on 5/21/08. Seven medical records were reviewed. Hospital policies were reviewed. Staff were interviewed.

The medical records of 7 patients who were treated in the emergency room (ER) for traumatic injuries were reviewed. All 7 patients had received x-rays and/or CT scans. One record documented a 53 year old female who was admitted to the ER, on 12/27/07 at 2:00 PM, following a motor vehicle accident. She had a history of low back pain and had undergone back surgery approximately 3 months earlier. She complained of back and hip pain. She also had pain and spasms when she moved her legs. The physician ordered x-rays of the patient's chest and lumbar spine. These were done. The report by the radiologist, dictated 1/1/08, stated "IMPRESSION: 1. Evidence of lumbar fusion at L4-5, which has been performed since the prior exam from August 9, 2007. 2. New compression fracture at L3 when compared to the exam from August 9, 2007. 3. Mild endplate spurring in the lumbar spine at L2 and L3."

The EMERGENCY ROOM NOTE by the ER physician, dated 12/27/07, stated "BACK: No redness, swelling, or bruising but marked tenderness noted over lower lumbar spine. Some muscle spasm. No other abnormality noted. Range of motion not attempted. Patient reported severe pain with even attempt to lift her leg slightly. Unable to sit up or ambulate to any active testing." The note stated the patient's chest x-ray was negative for disease but did not mention the lumbar spine x-ray. The patient was admitted to the hospital for observation. She complained of pain in her right hip through out her stay. Nursing notes documented pain in her hip but did not document pain in her back. At 4:20 AM on 12/28/07, the nursing note stated she ambulated with a walker. It said she "DID WELL BUT DOESN'T LIKE TO PUT WT ON (RIGHT) LEG." At 8:02 AM, the nurse documented the patient was sitting up in bed. She was discharged home with her family with a walker at 11:15 AM on 12/28/07. A physician discharge summary, dictated on 1/3/08, stated the patient had right side pain controlled with oral medication. It also stated the patient was ambulating with a walker which was normal for her. Under diagnoses, the physician stated the patient was "admitted for pain control status post MVA with contusion, right hip. She had a syncopal event...however, there is no evidence of acute head trauma." The lumbar fracture was not mentioned. The summary stated the patient was to follow up with her primary care provider. However, no specific discharge instructions were present in the record.

Records of the other 6 ER patients contained documented evidence that x-rays had been read in a timely manner and treatment had been rendered in accordance with the x-ray findings. All of the remaining 6 records contained copies of discharge instructions.

The physician, who cared for the above patient following discharge from the ER, was interviewed on 5/21/08 at 3:15 PM. He said the ER physician should have viewed the x-ray in the ER and completed a preliminary reading. He stated he was not aware that lumbar x-rays had been obtained during the patient's hospital stay. He said a radiologist in another town read x-rays for the hospital once per week. He said it appeared the radiologist read the lumbar x-ray on 1/1/08 and probably notified his office of the findings on 1/2/08. He could not absolutely say his office had received the x-ray report because he thought it would have been sent to a physician assistant in his office. The ER physician was not available for interview. The patient, who was interviewed on 5/27/08 at 1:40 PM, stated she had not been informed of the lumbar x-ray findings while she was at the hospital. She said she did not learn of the fracture until a CT scan was performed on 1/23/08.

The Manager of Radiology and the Director of Radiology were interviewed together on 5/21/08 at 3:50 PM. They stated the ER physician on duty on 12/27/07 was competent and normally read x-rays while the patients were in the ER.

Victoria Alexander

June 5, 2008

Page 3 of 3

They said currently the radiologist came to the hospital every Wednesday to read x-rays that had been taken the previous week. Reports were then generated and sent to the providers. They said the hospital had no policy to ensure ER physicians read x-rays or to ensure patients were informed of the findings in a timely manner. It was noted the hospital had recently installed hardware to allow the radiologist to read x-rays remotely which would promote faster turn around times for readings. This system was expected to be on line in the second half of June, 2008.

At least one patient had experienced delays in treatment due to the inability of the hospital to ensure x-rays were read by a physician in a timely manner. A deficiency was cited at 42 CFR 485.627(a).

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

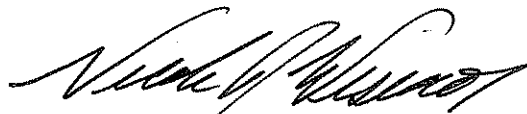
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/mlw